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Background and Purpose

Other than a few integrated dual eligible initiatives under section 1115 demonstration authority, there is no requirement to link Medicare and Medicaid quality improvement efforts for dual eligibles. Likewise, Medicare performance measures, such as the Health Plan Employer Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey and Health Outcomes Study (HOS) may differ from State Medicaid performance measures. Even where the information is coordinated, it is collected and sent to different sources for measuring performance. Finally, CMS receives performance measures from the Medicare Advantage Organization level, while States receive the information from the plan level.

CMS adopted HEDIS®, CAHPS®, and HOS as the mandated reporting for all Medicare managed care plans. CMS is working with the National Committee for Quality Assurance (NCQA) to identify appropriate measures for Special Needs Plans (SNPs). Once the SNP-specific measures are tested and approved, they will be mandatory for all SNPs, replacing the current HEDIS® data reporting. CMS requires the CAHPS® and the modified HOS for all SNPs.

Medicaid managed care plans that enroll dual eligibles have to report the same measures, or another set of measures, to the State.

The purpose of this “How To” Guide is to provide guidance on how managed care quality requirements may be integrated for dual eligibles and to provide examples of best practices from those States that have integrated the reporting requirements for Medicare Advantage Plans with reporting requirements for a Medicaid managed care contract.

Questions and Answers on Quality Issues

1. Does CMS allow integrated Medicare and Medicaid quality reporting?

Yes. CMS encourages health plans to work with the State Medicaid Agency early in the process of developing a dual eligible plan. There are health plans that enroll dual eligible beneficiaries without a wrap-around Medicaid product and those that do contract with the State. CMS believes that integration at some level can occur with or without a State contract for wrap-around services.

Health plans that intend to negotiate a contract with the State to provide capitated services for Medicaid should begin discussing quality reporting requirements during the contracting process. The quality reporting requirements would most likely be included in the contract.

There are several reporting requirements for Medicare health plans. One requirement is to collect HEDIS®, CAHPS® and HOS data. The other requirements are to

conduct quality improvement projects to improve health outcomes and enrollee satisfaction, and to develop criteria for a chronic care improvement program.

CMS has separate quality reporting requirements for State Medicaid managed care programs (see 42 CFR Part 438, Subparts D and E). Medicaid managed care plans must have a quality assessment and performance improvement program in which the plans submit performance measurement data and conduct performance improvement projects. These activities are subject to an annual external quality review (EQR). States must also develop, review, and update a State quality strategy that includes these and other activities.

States may give plans flexibility to tailor CMS Medicaid requirements to fit their individual programs. States may also add additional requirements. Having a dialogue between the State and health plans can generate ideas as to how these projects can meet both Medicare and Medicaid reporting requirements.

At this time, other than States using demonstration authority, CMS does not permit a Special Needs Plan (SNP) to use Medicaid measures as a proxy for Medicare measures when those measures differ from the Medicare requirements. States may impose additional measures in their Medicaid contracts with a plan that is also a SNP, or a State may use the same Medicare measures as indicated above.

2. Can the Medicare Advantage health plan integrate its quality improvement project with its Medicaid quality assessment and performance improvement program?

Yes. States have flexibility in defining the performance measures and performance improvement projects for their Medicaid contracts (42 CFR 438.200 and 438.242). CMS encourages States to consider using the Medicare Advantage requirements to support such integration by a plan, if relevant to enrollees of both programs. While a State may agree to use Medicare performance measures or performance improvement projects, they are not required to do so or to limit the requirements solely to the Medicare requirements.

3. *Can the State agree to use information from Medicare to meet the Medicaid requirements for external quality review (EQR)?*

Medicaid Plans that only enroll dual eligible individuals

To avoid duplication in the case where the Medicaid managed care plan serves only dual eligible individuals, the State may use data obtained from CMS-approved Medicare Advantage performance projects. The State has the option under §438.360 of relying on Medicare information for all three mandatory EQR activities if it chooses to do so, and the MA plan meets the requirements listed under this section.

Medicaid Plans that enroll dual eligibles and other Medicaid populations

In this case, the State may rely exclusively on information provided by Medicare for the purpose of providing information to the EQR organization on the mandatory EQR activity described in 438.358(b)(3), but the Medicaid plan would not be exempt from separate validation of performance measures and performance improvement projects under Medicaid.

Exemption from EQR

Under §438.362, the State has the option of exempting altogether a Medicaid plan from EQR if the plan also has a current Medicare Advantage contract and meets the other requirements of that section. Unless a State opts to exempt a health plan from EQR altogether, CMS would require the State to have an EQR produce the technical report required under §438.364 even if the data for the mandatory EQR activities came from Medicare.

4. *Can a Medicare Advantage health plan use the Part D medication therapy management program to satisfy any of the Medicare or Medicaid quality improvement project reporting requirements?*

Yes. The Medicare Advantage health plan can use the medication therapy management program to satisfy the requirements under Medicare and Medicaid that pertain to assessing the quality and appropriateness of care and services (42CFR§438.204, 208, 240 and §422.152). For example, a Medicare Advantage/Prescription Drug Plan is required to assess whether covered Part D drugs prescribed are used appropriately to optimize therapeutic outcomes. This would be an example of assessing the quality and appropriateness of care, and possibly services.

A State may choose to build its medication therapy management program into its health plan contract requirements. In this case, there would not be a duplication of requirements.

5. *Is CMS considering any new Medicare quality reporting requirements for SNPs?*

The following is what CMS expects SNPs to report for 2007 but we are continuing work in this area and will provide future guidance as it becomes available.

CMS intends to require all SNPs to report only a core subset of the HEDIS® measures beginning 2007. For those Medicare Advantage Organizations that have other plans in addition to SNPs, and report all of their data at the Organization level, CMS will require them to separate out their SNP reporting since the requirement for those plans will be different in 2007. CMS will use the Modified HOS in 2007 instead of the HOS that is collected currently. Additionally, CMS is working with the NCQA to identify and develop customized measures for SNPs.

6. *What are some options for integrating Medicare and Medicaid reporting?*

Below are four examples of how plans may integrate Medicare and Medicaid reporting requirements.

Example 1: Integrated Reporting (Identical Requirements)

The State Medicaid managed care program contains contract language that incorporates all of the same quality improvement requirements for their Medicaid managed care program as CMS has for the Medicare Advantage Program.

The contract language could read as follows:

The Contractor agrees to operate an ongoing quality improvement program in accordance with Section 1852(e) of the Social Security Act (the Act) and regulations at 42 CFR 422.152.

The Contractor agrees to conduct a Chronic Care Improvement Program (CCIP) relevant to its membership in accordance with section 1852(e) of the Act and 42 CFR 422.152(c), and to submit the annual report on the Contractor’s CCIP to CMS and the appropriate State Agency.

The Contractor agrees to conduct quality improvement projects and to measure performance using standard measures required by CMS, and to report results to CMS and the appropriate State Agency. Standard measures will include, but not be limited to:

- Health Plan and Employer Data Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems(CAHPS®) Survey; and
- Health Outcomes Survey (HOS).

Example 2: Integrated Reporting (Inclusion of Certain Requirements)

This example represents a State Medicaid Agency that requires its contractors to incorporate the following Medicare requirements (as evidenced in the crosswalk attached) into their Medicaid contract:

The Program Contractor shall execute processes to assess, plan, implement, evaluate, and as mandated, report quality management and performance improvement activities that include at least the following [42 CFR 438.240(a)(1) and (e)(2)]:

1. Conducting Performance Improvement Projects (PIPs);
2. QM monitoring and evaluation activities;
3. Investigation, analysis, tracking and trending of quality of care issues, abuse and/or complaints that includes:
 - a) Acknowledgement letter to the originator of the concern;
 - b) Documentation of all steps utilized during the investigation and resolution process;
 - c) Follow-up with the member to assist in ensuring immediate health care needs are met;
 - d) Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns;
 - e) Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern; and
 - f) Evidence of the resolution implemented.
4. Medicaid managed care mandated Performance Measures; and
5. Credentialing, re-credentialing and provisional credentialing processes for providers and organizations [42CFR 438.206(b)(6)] [42 CFR 438.214].

Contractors must have a process in place to monitor services provided in home and community-based settings. The process may be a collaborative one that involves quality management and case management staff, including a case manager. The Contractor must develop a process that, at a minimum, meets the requirements specified in Manual instructions.

Medicaid has established a uniform credentialing, re-credentialing and provisional credentialing policy. The Program Contractor shall demonstrate that its providers are credentialed and [42 CFR 438.214]:

1. Shall follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the Program Contractor.
2. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
3. Shall not employ or contract with providers excluded from participation in Federal health care programs.

The Program Contractor shall submit a written QM plan, a QM evaluation of the previous year’s QM program, and Quarterly QM Report that addresses its strategies for performance improvement and conducting the quality management activities described in this section. The Program Contractor may combine its Quality Management Plan with the Plan that addresses Medical Management.

Program Contractors must meet Medicaid stated Minimum Performance Standards (All Performance Measures described below may apply to all member populations [42 CFR 438.240(a)(2);(b)(2) and (c)].) However, it is equally important that Program Contractors continually improve their performance measures outcomes from year to year. Program Contractors shall strive to meet the benchmark established by Medicaid. Medicaid has established three levels of performance:

Minimum Performance Standard – A Minimum Performance Standard is the minimal expected level of performance by the Program Contractor. If the Program Contractor does not achieve this standard, or the measure rate declines to a level below the Minimum Performance Standard, the Contractor will be required to submit a corrective action plan and may be subject to sanctions.

Goal – A Goal is a reachable standard for a given performance measure for the Contract Year. If the Program Contractor has already met or exceeded the Minimum Performance Standard for any measure, the Program Contractor must strive to meet the established Goal for the measure(s).

Benchmark – A Benchmark is the ultimate achievable standard. Program Contractors that have already achieved or exceed the Goal for any performance measure must strive to meet the Benchmark for the measure(s). Program Contractors that have achieved the Benchmark are expected to maintain this level of performance for future years.

A Program Contractor must show demonstrable and sustained improvement toward meeting the Medicaid Performance Standards. In addition to corrective action plans, Medicaid may impose sanctions on Program Contractors that do not meet the Minimum Performance Standard and do not show statistically significant improvement in a measure rate and/or require those Contractors to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. Medicaid may require a corrective action plan of any Program Contractor that shows a statistically significant decrease in its rate, even

if it meets or exceeds the Minimum Performance Standard. Medicaid must receive the corrective action plan within 30 days of receipt of notification. Medicaid must approve this plan prior to implementation. Medicaid may conduct one or more follow-up on-site reviews to verify compliance with a corrective action plan.

Performance Measure

The Program Contractor shall comply with Medicaid quality management requirements to improve performance for all established performance measures. Medicaid will monitor these activities during the Operational and Financial Review. CMS has been working in partnership with states in developing core performance measures for Medicaid and SCHIP programs. The current Medicaid established performance measures may be subject to change when these core measures are finalized and implemented. The current quality performance measures include:

1. Diabetes Performance Measures;
2. Initiation of Services Performance Measures; and
3. EPSDT Participation.

Quality Improvement

Program Contractors shall implement ongoing quality assessment and performance improvement programs for the services furnished to members [42 CFR 438.240(a)(1)]. Basic elements of the Program Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the following requirements:

Quality Assessment Program

The Program Contractor shall have an ongoing assessment program for services [42 CFR 438.240(a)(1)].

1. The Performance Improvement Projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
2. The Program Contractor must [42 CFR 438.240(b)(2) and (c)]:
 - a) Measure and report to the State its performance, using standard measures required by the State, or as required by CMS.
 - b) Submit to the State data specified by the State, that enables the State to measure the Program Contractor’s performance; or
 - c) Perform a combination of the activities.
3. The Program Contractor must have in place a process for internal monitoring of Performance Measure rates, using a standard methodology established or adopted by Medicaid, for each required Performance Measure. The Contractor’s Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its administration. It also will report this Performance Measure data to Medicaid in conjunction with its Quarterly EPSDT Progress Report, according to a format developed by Medicaid.

Performance Improvement Program

Program Contractors must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions; and
4. Planning and initiation of activities for increasing or sustaining improvement.

The Program Contractor must report the status and results of each project to the State as requested. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information annually on quality of care [42 CFR 438.240(d)(2)].

Data Collection Procedures

When requested, the Program Contractor must submit data for standardized Performance Measures and/or Performance Improvement Projects as required by the State within specified timelines and according to the procedures for collecting and reporting the data. The Program Contractor is responsible for collecting valid and reliable data, using qualified staff and personnel to collect the data. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Program Contractor.

Example 3: Integrated Reporting (Population-Specific)

This State example demonstrates work that was done between State entities and CMS to incorporate Medicaid/Medicare requirements that are most meaningful for the population served.

The contract language could read as follows:

The Contractor must report clinical indicator data, including certain HEDIS 3.0 reporting set measures that are appropriate for the enrolled population. The Contractor must analyze clinical indicator data to identify opportunities for improvement and initiate quality management activities.

The following clinical indicator data must be reported annually. The technical definitions of such indicators and the reporting format will be provided jointly by CMS and the State:

1. Preventive Medicine

- a) Influenza immunization rates,
- b) Pneumococcal vaccination rate,
- c) Fecal occult blood testing,
- d) Mammography screening,
- e) Eye examination every two years,
- f) Hearing examination every two years,
- g) Screening for alcohol abuse.

2. Acute and Chronic Disease

- a) Enrollees Diagnosed with Diabetics Mellitus
- b) Enrollees Diagnosed with Chronic Obstructive Pulmonary Disease (COPD)
- c) Enrollees Diagnosed with Congestive Heart Failure (CHF)
- d) Enrollees Diagnosed with Depression
- e) Enrollees Diagnosed with Dementia

Encounter Reporting

The Contractor must meet any diagnosis or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations. CMS and the State will provide the Contractor with a nine-month advance notice of such a requirement. During the nine-month period, CMS or the State will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements by the end of the nine-month period.

Enrollee Orientation Performance

The Contractor must evaluate the effectiveness of enrollee orientation activities and report the results to CMS and the State on each anniversary of the start date of the Contract, specifying the costs and benefits of implementation and the lessons learned. The Contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for providers and administrative staff.

Complaints and Appeals

- 1. On a monthly basis, the Contractor must report the number and types of Complaints filed by Enrollees and received by the Contractor, specifying how and in what periods they were resolved. The Contractor must cooperate with CMS and the State to implement improvements based on the findings of these reports.
- 2. The Contractor must report the number, types, and resolutions of appeals filed, including, for external appeals, whether the external review was by the CMS Independent Review Entity or by the State Board of Hearings.

Disenrollment Rate

The Contractor must report annually voluntary disenrollment rates and reasons. The Contractor must track such information and develop interventions to address opportunities for improvement identified through the analysis of voluntary disenrollments.

Institutional Utilization Data

The Contractor must report institutional utilization data annually for enrollees, including, but not limited to the following, by gender categories and age groups as defined by and in the format provided by CMS and the State:

1. Rate of Acute Hospital Admissions;
2. Rate of Preventable Hospital Admissions (for example, pneumonia, COPD, CHF, dehydration and urinary tract infection);
3. Rate of Nursing Facility Admissions;
4. Enrollees Discharged from a Nursing Facility;
5. Enrollees Residing in Nursing Facilities; and
6. Rate of Chronic Hospital Admission.

Community Health Service Utilization

The Contractor must report community health service utilization data for enrollees, including number of units and units per 1,000 enrollees by age group and gender categories.

Enrollees Medically Eligible for Nursing Facility Services

The Contractor must report quarterly on enrollees who are medically eligible for nursing facility services, by age group and gender.

Behavioral Health Utilization Data

The Contractor must report behavioral health utilization data annually for enrollees as specified by CMS and the State by age group and gender categories.

Functional Data

The Contractor must report the need for assistance with Activities of Daily Living (ADLs) annually for all enrollees by age and gender. These data will be collected in accordance with the Minimum Data Set (MDS), and will include the number of enrollees per 1000 needing limited assistance and number of enrollees per 1000 needing extensive or total assistance with mobility, transfer, dressing, eating, toilet use, personal hygiene, or bathing.

Mortality Data

The Contractor must report mortality data annually, by age and gender.

Medications

The Contractor must report enrollee-specific prescription data through the MDS 2.0 for nursing facility residents and the MDS-HC for home care.

Example 4: Partially Integrated Reporting

1. The State works with the appropriate departments within the State to negotiate for requirements related to the Medicare/Medicaid population.
2. For Medicaid purposes, the State can choose to adopt all or some of the Medicare requirements in those instances that the beneficiary has managed care for both Medicare and Medicaid Services.
3. The State already has a relationship with the CMS Regional Office to discuss measures that are meaningful for the population.
4. The health plan submits the quality report to the State and another submitted to CMS (through its NCQA contractor).
5. The State requires separate requirements for its Medicaid only members. For example, long term care measures and measures for persons with disabilities are an additional requirement.

REPORTING REQUIREMENTS AND PROCESSES

HEDIS®, CAHPS® and HOS Reporting Requirements for All Medicare Advantage Plans *

1. HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS®)
 - a. A subset of these measures is required for all Special Needs Plans.
 - b. A subset of these measures is required for PPOs.
2. MEDICARE CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) SURVEY
 - a. CMS is exploring the feasibility of using the CAHPS survey for reporting at the plan level for all Special Needs Plans.
3. MEDICARE HEALTH OUTCOMES STUDY (HOS)
 - a. The HOS-modified will be used for Special Needs Plans.

*Although the report requirements are the same for all plans, there are differences in the specific measures reported under HEDIS. In addition, all Medicare Advantage Plans must have a quality improvement program that includes quality improvement projects and a chronic care improvement program.

General Information about the HEDIS®, CAHPS®, and HOS reporting processes

HEDIS®

The Health Plan Employer Data and Information Set is designed to ensure that purchasers, regulators and consumers have the information they need to reliably compare the performance of managed care plans. The performance measures in HEDIS® relate to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. The National Committee for Quality Assurance (NCQA) sponsors, supports and maintains HEDIS®. CMS’ HEDIS® Information Summary report consists of measures within five domains: Effectiveness of Care, Access to/Availability of Care, Health Plan Stability, Use of Services, and Health Plan Descriptive Information. We chose these measures since they capture important aspects of health care delivery, including provision of preventive health care, management of chronic conditions, and acute care.

NCQA collects HEDIS® data from Medicare Advantage health plans. NCQA provides CMS with the data. CMS ranks the data nationally, regionally and by State. Public reporting of health plan data can be found at www.medicare.gov/Download/DownloadDB.asp. In the Medicare Health Plan Compare downloadable databases, there are eleven tables of data—for example, average disenrollment and the average of quality measures by State.

CAHPS® Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is a tool for documenting the experience members have with their Medicare Managed Care organizations. The proportion of positive experiences among enrollees is an indicator of the quality of various aspects of care and customer service provided by the health plan. Each year, CMS sends a survey to a sample of members of each Medicare managed care plan. The survey is conducted from January – April. The 2005 MA-CAHPS® Survey contained 95 questions, organized into the following sections: Your Personal Doctor or Nurse, Getting Health Care from a Specialist, Your Health Care in the Last 6 months, Other Health Services, Your Health Plan, Appeals and Complaints, and About You.

CMS made a considerable effort to reach the Spanish-speaking beneficiary population for the MA-CAHPS® Survey. Bilingual interviewers were available, or CMS sent a Spanish language survey to the beneficiary.

The CAHPS® Information Report gives CMS a relative sense of how Medicare beneficiaries that receive these surveys rate their health plans. Consumers can view some of the results from the MA-CAHPS® on www.medicare.gov in the “Medicare Personal Plan Finder” and “Medicare Health Plan Compare” tools. Consumers can also call 1-800-MEDICARE to receive information on the seven measures listed above and to request additional information about MA-CAHPS®.

Medicare HOS

CMS annually collects the Medicare Health Outcome Survey. The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. All managed care plans with Medicare Advantage (MA) contracts must participate. The survey is a measure of a health plan’s ability to maintain or improve the physical and emotional health of its Medicare beneficiaries over time.

One thousand Medicare beneficiaries, who were continuously enrolled in the same plan for six months, are randomly sampled from each plan and surveyed every spring (i.e., a survey is administered to a different baseline cohort, or group, each year). Two years later, these same respondents are surveyed again (i.e., follow-up measurement).

Data files are aggregated and released to CMS, MA Plans, Quality Improvement Organizations (QIOs), and other data users by early fall of the following year. NCQA is responsible for the scientific development and implementation of the HOS measure. NCQA-certified survey vendors collect HOS data. The Health Services Advisory Group (HSAG) is the CMS contractor responsible for data cleaning, analysis, dissemination, and applied research. HSAG also functions as the HOS data repository.

Medicaid and Medicare Quality Requirements Crosswalk *

Requirement	Medicaid Regulatory Citation	Medicaid Requirement	Medicare Requirement §422.152
State Responsibilities:	§438.202	X	None
(a) Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs (b) Obtain input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it (c) Ensure that the plans comply with standards established by the State (d) Conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically as needed (e) Submit to CMS of copy of the initial strategy, revised strategy and the implementation and effectiveness of the strategy			
Elements of a Quality Improvement Program:	§438.204	X	X
(1) Assess the quality and appropriateness of care and services furnished of all contracts and to individuals with special health care needs	§438.204 §438.240(b)(4) §438.208(c)(2)	X	
(2) Identify the race, ethnicity and primary language spoken and submit to State	§438.204(2)	X	Similar HEDIS measure
(3) Regularly monitor and evaluate the health plans for compliance	§438.204(3)	X	CMS RO performs
(4) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of and access to the services covered under the contract	§438.204(3)(d)	X	CMS RO performs. In addition NCQA contractor receives data
(5) Appropriate use of intermediate sanctions	§438.204(3)(e)	X	X
(6) An information system that supports initial and ongoing operation and review of the State’s quality strategy	§438.204(3)(f)	X	MCO must have an information system
Have a chronic care improvement program that includes methods for identifying the enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program			X
Conduct quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction that focus on specified clinical and non-clinical areas and that involve measurement of	§438.240(b)(1)	X	X

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performance, system interventions including the establishment or alteration of practice guidelines, improving performance, systematic and periodic follow-up on the effect of the intervention			
Follow written policies and procedures that reflect current standards of medical practice	§438.236	X	X
Have in effect mechanisms to detect both under-utilization and over-utilization of services	§438.240(b)(3)	X	X
Measure and report performance using the measurement tools required by CMS and report performance to CMS	§438.350(e) §438.352	X	X
Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them			X
PPO plans must have a provider network that has agreed to a contractually specified reimbursement for covered benefits regardless whether the benefits are provided within the network of providers		N/A	X
Annual review, at least, for a formal evaluation of the impact and effectiveness of the quality improvement program	§438.240(d)	Quality outcomes, timeliness and access	X
The organization must correct all problems that come to its attention through internal surveillance, complaints or other mechanisms	§438.364(a)(5)	X	X

Medicare Advantage Prescription Drug (MA/PD) and Prescription Drug (PD) Quality Requirements

Requirement	Regulatory Citation
Drug utilization management program must include:	§423.153
<p>(a). Quality assurance program must have established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use that include:</p> <ol style="list-style-type: none"> 1. Network providers that comply with minimum standards for pharmacy practice as established by the States 2. Concurrent drug utilization review systems, policies and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee in a sponsor’s Part D plan and the point of sale or point of distribution 3. Retrospective drug utilization review systems, policies and procedures designed to ensure ongoing periodic examination of claims data and other records, through computerized drug claims processing and information retrieval systems, in order to identify patterns of inappropriate or medically unnecessary care among enrollees 4. Internal medication error identification and reduction systems 5. Provide CMS information regarding its quality assurance measures and systems 	
<p>(b). Medication therapy management program(MTMP) established that:</p> <ol style="list-style-type: none"> 1. Is designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use; 2. Reduces the risk of adverse events including adverse drug interactions. Is targeted to beneficiaries who: <ul style="list-style-type: none"> • Have multiple chronic diseases • Are taking multiple Part D drugs • Are likely to incur annual costs for covered Part D drugs that exceed the predetermined level set by the Secretary (2006 -2007 level is \$4000) 3. May be furnished by a pharmacist or other qualified provider 4. May distinguish between services in ambulatory and institutional settings 5. Is designed for targeted beneficiaries as defined as having multiple chronic diseases and are likely to incur annual costs that exceed \$4000 6. Must be developed in cooperation with licensed and practicing pharmacists and physicians 7. Must coordinate with any care management plan established for a targeted individual under a chronic care improvement program under section 1807 of the Social Security Act 8. Disclose to CMS, upon request, the amount of the management and dispensing fees and the portion paid for the MTMP services to pharmacists and others 	
(c). Consumer satisfaction surveys are conducted by CMS similar to the surveys it conducts of MA enrollees	§423.156
<p>(d). Electronic prescription program:</p> <ol style="list-style-type: none"> 1. Compliance with electronic standards as required by CMS 2. A MA-PD plan may provide for a separate or differential payment to a participating physician that prescribes covered Part D drugs. Any payments must be in compliance with applicable Federal and State laws related to fraud and abuse, including the physician self-referral prohibition and the Federal anti kickback statute. 	§423.159

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(e). Quality improvement organization activities: 1. QIOs are required to offer providers, practitioners and Part D sponsors quality improvement assistance pertaining to health care services including those related to prescription drug therapy 2. Part D sponsors are required to provide specified information to CMS for distribution to the QIOs as well as directly to QIOs.	§423.162
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- * **The Medicaid Medicare Crosswalk and the MA/PD, PD tables are not intended to be substituted for the Code of Federal Regulations (CFR) Parts 422, 423 or 438, or to be used in lieu of information published by CMS interpreting the CFR, such as manual instructions, interpretive rules, statements of policy or guidelines of general applicability.**